STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
P.O. Box 45010, Olympia, Washington 98504-5010

June 26, 2002

Ms. Linda A. Ruiz
Regional Administrator
Department of Health and Human Services
Center for Medicare and Medicaid Services
2201 Sixth Avenue, M/S RX-43
Seattle, Washington 98121

Dear Ms. Ruiz:

I am writing in response to your May 9, 2002 letter and the DRAFT Washington Medicaid Assessment Report Community Alternatives Program Waiver. This report raises a variety of issues concerning management and operation of the Community Alternatives Program (CAP) home and community-based services waiver. I appreciate the extra time we were given to prepare this response. The report includes specific recommendations and related findings. In addition to this letter we are enclosing a matrix that provides a summary with timeframes for our response to the recommendations.

The Department of Social and Health Services (DSHS) takes the deficiencies cited in the CMS Review seriously and will respond to each recommendation and issue cited in the Centers for Medicaid and Medicare Services (CMS) Review. Many recommendations are interrelated and the department intends to respond in a coordinated and systematic way. All of the recommendations have impact on the way the department manages the Home and Community Based Services (HCBS) Waiver serving people with developmental disabilities. The department will take action to correct [any] deficiencies by implementing the following steps.

> **The Division Of Developmental Disabilities (DDD) developed needed revisions to the CAP Procedures Manual during the spring and summer of 2001 as CMS was conducting their review. The revised CAP Procedures manual (sent under separate cover), which was released in the late summer of 2001, addresses many of the cited deficiencies. Field staff were trained in the fall of 2001 on the new provisions. Revisions to the Manual (as a result of our internal review as well as the CMS Review) dealing with specific citations below will provide additional and specific guidance to case managers and supervisors. Moreover, a systematic comprehensive training package will be implemented for case managers and supervisors. The curriculum will include training on policies and procedures including, but not limited to Plans of Care, Assessment Responsibilities, Fair Hearing and Appeal Rights, Client Choice, Client Health, and Health and Safety Monitoring.**
>
> **Case managers and supervisors are the first line in resolving these problems. As a quality control measure, however, the division will establish a Compliance and Monitoring Unit. Part of the unit's responsibilities will be to implement monitoring protocols for key waiver compliance elements as identified in the CMS Review, Plans of Care, Level of Need Determination, etc.**

Several recent studies of DDD have demonstrated that a credible management information system is an important part of service delivery. The department is developing a system that will simplify case management client assessment, planning and service data entry. The system will have links to the multiple systems, including MMIS, which case managers use to deliver Waiver services.

In addition, the division is updating the Case/Management Workload Standards Study that was used to justify the DSHS's request for additional case management staff in the budget request for 2001-03. By October 2002 the updated study will provide current data on FTEs needed to accomplish essential work.

The division will build on the regional quality assurance projects and innovations that were noted in the CMS Assessment Report and develop quality assurance capacity in all regions. While the Compliance and Monitoring Unit will be responsible for consistent application of policies and procedures that are internal to the department and its staff, quality assurance staff will be responsible to check on the quality of services delivered and the experience of the client receiving the service.

In 2002, the division received an appropriation from the legislature of $8,550,000 to specifically address the residential, employment/day program and other service needs of Waiver participants. The division also received $2.3M to add case managers, supervisors, and administrative support.

The Report indicated that Washington should examine the way it operates its Waiver and consider different operational strategies. The department received additional resources from the legislature to improve Waiver management in DDD including plans to pursue a multiple waivers with CMS. These waivers would have basic benefit packages and benefit limitations per the narrative of the Report findings and recommendations.

Lastly, it is important that our corrective action plan be incorporated into our overall strategy for improving services. The policy direction we are pursuing will establish a transparent support continuum for our clients and their families and there will be specific checkpoints for the provision of needed supports and residential alternatives. The policy direction will describe the state's commitment to an effective community services system to prevent the need for people to leave their homes and communities while establishing the rationale for the number of ICF/MR facilities and space that are needed to accommodate the state's population.

At the same time, there are recommendations and issues in the CMS report with which Washington disagrees. The report emphasizes that problems with documentation puts clients at risk. The report also states, however, that the elements that deal with actual service delivery such as certification, evaluation, incident management and quality assurance all work well to support clients health and welfare. We are particularly concerned with statements on page 8, which indicates that CAP participants "...face unreasonable risks to their health and welfare…", and page 15, which states that CAP clients are "…at undue risks to their health and well-being…." CMS does not provide actual client observation or examples to substantiate these claims.

Finally, Washington disagrees with federal interpretations of regulation and policy that are being used to disallow federal financial participation (FFP) for services for Washington

Waiver recipients. We intend to pursue a vigorous defense of practices that we believe are consistent with federal policy and intent with regard to waiver services.

Each of the recommendations and findings/issues is repeated below followed by the State's response.

Recommendation 1. Follow-up on the individual deficiencies mentioned in the report and take the steps necessary to resolve each problem.

Under separate cover WA is providing information from Adult Protective Services about the investigation they performed regarding the client who used Facilitated Communication to allege abuse. We believe the allegation was investigated and handled properly.

WA intends to ensure that clients/families have sufficient information to make an informed choice about the use of Facilitated Communication. The information that we will provide complete with reference material was provided at the beginning of the DSHS/DDD meeting with CMS on 6/14/02.

Under separate cover WA is providing some of the detail relating to service delivery to the client whose condition was alleged to have deteriorated dramatically as a result of no assessments and therefore no intervention. (see Recommendation # 8**) The documentation clearly shows reliable service intervention on behalf of the client. WA is not disputing that required documentation was not completed. WA is asserting that service delivery was accomplished in a timely manner and met the clients needs.**

With respect to the physician visits, we maintain that the Naturopathic treatment interventions are in addition to the person's regular physician visits. As stated in Recommendation #2 of this report, however, DDD has implemented a plan for the Quality Assurance Office to monitor completion of corrective actions statewide. This procedure should eliminate misunderstandings about follow-up on corrective actions.

Other individual citations are followed-up in the remainder of the body of this report.

Recommendation 2. Instruct case managers on the importance of clients maintaining ongoing relationships with their physicians and dentists. The instructions should explain that alternative care must not be used to replace medical care and communication paths must be established among all of a client's health care providers. The State should also establish procedures to ensure case manager performance in this area is adequately monitored and evaluated.

DSHS RESPONSE: This recommendation should be withdrawn from the CMS report. Reviewer's concerns were based upon a single DDD contracted agency and do not apply to other CAP participants. In fact, the findings reflect choices clearly made by individuals and families. Although they raised concerns, the reviewers do not claim that these choices have had an adverse affect on the people involved. In addition as per the response to Recommendation 1, the agency asserts that it is their policy that clients visits to Naturopaths are in addition to and in combination with clients regular physician visits.

We agree that there is an apparent lack of clear documentation on the part of this particular agency indicating individuals are receiving annual physical examinations. As a result of the state certification review, the provider has been instructed to revise the process for documenting health-related information and train staff in this area. The Division will ensure these changes are made through the Quality Assurance process.

We agree that procedural requirements and necessary practices that are not accomplished in the required timeframes may have potential to put clients at risk and warrant attention and implementation of a corrective action plan. Further, we think we have addressed these issues in the following ways:

- **The 2001 CAP Procedures Manual directs case management activities regarding the identification of medical needs and medications and their inclusion in the plan of care (pages 45 & 49) and quality assurance in those areas (page 17).**

- **WAC 388-820-690 indicates that for clients who receive an average of thirty hours or more of residential service per month, the service provider must ensure the individual received an annual physical and dental examination unless the appropriate medical professional gives a written exception. The Residential Evaluation/Certification protocol (sent under separate cover) covers this on page D.3. In the case of the provider in question, the most recent certification review (September 2001) indicated documentation did not clearly show that annual physical examinations were being completed. The division implemented corrective action. The provider must show compliance with the corrective action in a division review that will occur by December 31, 2002.**

- **WAC 388-820-700 indicates a client may refuse to participate in health care services and that residential service providers must document these situations. The Residential Evaluation/Certification protocol covers this on page D.3. The most recent certification review (September 2001) indicated the provider was in compliance with this requirement.** (Documentation is provided under separate cover)

- **Division Policy 5.06** (Client Rights—provided under separate cover) **indicates clients have the right to participate in the development of the plan for services and medical treatment, including the right to formulate Advance Directives, and to approve or reject any parts. The residential Evaluation/Certification protocol addresses this requirement on pages D.4, D.9, D.10, and D.11. The September 2001 certification review found the provider in compliance with these requirements. (**This review is provided under separate cover)

- **Compliance with WAC 388-820-690, WAC 388-820-700 and Policy 5.06 is monitored during provider certification evaluations, which occur at a minimum of every two years.**

- **With respect to individuals that reside with their family (i.e., do not receive service from a provider of residential support services), day-to-day oversight in this area is the primary responsibility of the individual (in the case of adults) and the family or the guardian in cases of guardianship.**

Recommendation 3. Implement procedures requiring case managers to ensure CAP participants who are considering accessing alternative health care and unproven treatments or processes are fully informed of the potential risks and benefits of each choice. Procedures should also be implemented to ensure this information is communicated to the client's representative/guardian.

DSHS RESPONSE: Reviewer's concerns were limited to a single DDD contracted agency and specifically address Facilitated Communication. Facilitated Communication is a method that has been proven as a useful tool to assist certain individuals to communicate. As with any method, it may not be effective with some persons and will predictably have varying success with others. Clients and their family/representatives chose to enter this provider's program in part because it offered this communication method. Nevertheless, when a client, client representative, and/or guardian is considering accessing Facilitated Communication, the case manager will provide them with written material (sent under separate cover) regarding the positive and negative aspects of this method.

Finding/Issue: When a client alleged seven separate incidents of physical abuse, there was no evidence suggesting the provider used other communication techniques to validate the client's allegations nor was there documentation showing the provider made an attempt to act upon the client's facilitative communication**.**

DSHS RESPONSE: Documentation contained in both the agency's files and those maintained by the Division of Developmental Disabilities clearly describe the incidents reported both to DDD and Adult Protective Services and the actions taken in response. (documentation provided under separate cover) **The agency staff and the case manager have worked intensively to reduce the problem behaviors cited using positive behavior support strategies, training materials for staff, and team meetings with the individuals involved.**

Recommendation 4. Remove all provisions from existing laws, regulations, policies and procedures that support or encourage denying CAP clients access to needed waiver services due to funding limitations. At the same time, laws and policies should be implemented recognizing the need to fully fund the waiver services CAP participants are assessed to need.

DSHS RESPONSE: We understand that this issue has been a concern of CMS. DSHS will sponsor legislation to eliminate statutory language denying waiver participant's access to needed waiver services due to funding limitations and explain to the Legislature the concerns of CMS. We will not use lack of funding as a defense when a fair hearing concerning access to services is held for a CAP Waiver client.

Finding/Issue: Regardless of the reason, withholding funds for needed CAP services is not acceptable. This practice directly conflicts with the approved CAP waiver and places people in situations where they face unreasonable risks to their health and welfare.

DSHS Response: The phrase "and places people in situations where they face unreasonable risks to their health and welfare" should be deleted from the CMS report. CMS's claim that CAP participants face unreasonable risks is unsubstantiated. The CMS report provides no information or evidence that CMS talked with or assessed the living situation of CAP participants that were denied funding as the basis to conclude that CAP participants were at risk.

Recommendation 5. Continue its efforts in improving DDD client access to effective mental health services and alcohol and substance abuse treatment.

DSHS RESPONSE: As of January 2001, the six (6) DDD Regions and fourteen (14) Regional Support Networks responsible for community mental health services developed and signed working agreements that cover four areas including: treatment planning, crisis management, discharge planning from State hospitals, and quality improvement.

Each region has a staff psychologist (expert in clinical practices in mental health services to people with developmental disabilities) who will continue to coordinate with local mental health delivery systems to provide responsive care to clients with mental health issues.

Each region developed medication management contracts with local professionals to ensure that medications will continue to be prescribed based on best practice information with regard to mental health conditions, monitored for individual treatment outcomes, and changed as necessary.

Each region will continue to develop working agreements or contracts as necessary with local mental health centers or other mental health treatment practitioners, depending on need, to address individual client therapeutic goals.

During December 2001 the Department completed a study that measured the number of DDD clients with substance abuse problems and investigated national best practices related to clients with developmental disabilities and substance abuse issues. The Department's Research and Data Analysis Division identified those clients who had been identified as having substance abuse issues and/or had accessed substance abuse treatment programs funded by the Department. University of Washington staff conducted a literature search of best practices in this area and contacted model programs throughout the nation. In response to these findings, the Division of Alcohol and Substance Abuse applied for and obtained a technical assistance grant. This funding will be used to provide division staff, providers and interested parties training on best practices related to clients with developmental disabilities who also have substance abuse issues. The training will be completed by December 2002.

Recommendation 6. Implement procedures that require plans of care for CAP clients be prepared in accordance with the approved waiver. The procedures should address each of the problems identified in the finding on plans of care and contain instructions that will ensure the problems do not occur in the future.

Findings/Issues. These were:

- One plan of care was prepared for an individual whose assessment showed he was not eligible for waiver participation;
- One case record did not contain a plan of care;
- Eight cases where a Voluntary Participation form could not be located;
- Thirty-eight people who did not have their plan of care updated within the required 12 month time period, with the time between updates ranging from 13 to 93 months;
- Two plans of care were based on assessments over 64 months old;
- Two cases where we could not determine when the client's previous plan of care was completed;

- Eighteen cases where no people were listed as participating in the development of the plan of care;
- Twenty-five cases where the documentation indicated the case manager did not participate in the development of the client's plan of care, including instances where service providers, instead of the responsible case managers, developed plans of care for CAP participants;
- Two plans of care where the client was not listed as participating in its development;
- Thirteen cases where there was no information documenting that the client's guardian/representative participated in the development of the plan;
- Twenty-two plans of care were missing the signature page or lacked the client/guardian/representative signature;
- Twelve cases where a letter, which did not include a statement regarding the client's appeal rights and some of which informed the client the plan of care was required only to secure federal funding for the cost of CAP services, was used to secure the client's agreement that a new plan of care was not necessary;
- Six instances where the letters agreeing to forgo a new plan of care were signed by the client's service provider rather than the client or her/his representative;
- Twenty-four instances where a standard, form letter, plan of care was used in which the typical template merely stated the client's goals and provided very general service descriptions that were not specific to the individual, and contained lists of general provider types rather than specifically identify the providers who would be providing services to the client;
- Six standard, form letter, plans of care which were open-dated;
- Numerous examples where the CAP plan of care referenced service plans used for Medicaid personal care services or developed by residential and vocational service providers, but the provider plans were rarely included in the clients' case files or covered the same time periods as the CAP plans of care;
- Twenty-seven cases where the plan of care did not contain information on 1) the client's last physician or dentist visit or 2) monitoring activities required to ensure compliance with, and the effectiveness of, treatment regimens;
- Six cases where the client was assessed to have needs that were not addressed in the plan of care;
- Future problems in this area could be prevented by educating staff on the importance of ensuring that clients are allowed to exercise their freedom of choice and by documenting these decisions in the clients' case files;
- DSHS did not have reliable evidence indicating CAP participants were not exposed to unreasonably high risks to their health and wellbeing;
- Interviews revealed CAP clients were being denied their choice among waiver services, while regulations preclude States from denying services to Medicaid beneficiaries for reasons other than medical necessity or a person's abusive utilization patterns; and
- Management also allowed plans of care to have effective dates prior to the date the plan of care was signed by the client/representative/guardian and encouraged case managers to request clients' representatives/guardians post-date [back-date] their signatures.

DSHS RESPONSE: We acknowledge deficiencies in paperwork and that documentation has been a problem. But the health and welfare of waiver recipients has been maintained.

To address the problems cited, DSHS has already substantially revised the CAP Procedures Manual (sent under separate cover) along with agency policies and

procedures and has provided training to all regional staff. Clear expectations have been developed for both staff and supervisors. Many of the issues raised by the CMS review are addressed by the new manual, which contains chapters on plan of care development/review, annual assessment, case record documentation, and change of status. It also contains the forms required for all actions/procedures connected with the waiver. Additional staff and management resources will be directed towards waiver management and compliance, including additional training for supervisors and case managers.

To ensure regional staff compliance with waiver requirements, the Division of Developmental Disabilities will establish, effective July 2002, a special unit comprised of 8.0 FTEs to monitor compliance with state and federal law, regulations, and policies. Included in the responsibilities of the unit will be a sampling of service plans to ensure waiver requirements are being met. The results of the monitoring activities will be shared with Regional Administrators and Field Services Administrators, who will ensure corrective action when needed.

Everyone on the waiver must indicate that her/his participation is voluntary. This requirement has been and will continue to be addressed through staff training on the new CAP Procedures Manual which states (page 30) "If, after reviewing the options, the individual continues to be interested in waiver services have them and their legal representative (if applicable) sign the Voluntary Participation Form." The revised CAP Procedures Manual that will be released November 1, 2002 will also indicate the Voluntary Participation Form must be signed and dated. Supervisors and the Compliance and Monitoring Unit will ensure Voluntary Participation forms are completed and in the client file.

The requirement for a POC has been and will continue to be addressed during staff training on the new CAP Procedures Manual that indicates (page 43), "When a person has been determined to be eligible for CAP services and has chosen to receive such services a Plan of Care (POC) must be developed and implemented within 90 days from the date of referral." Monitoring of compliance with this requirement will be the responsibility of supervisors and the Compliance and Monitoring Unit.

During staff training, it has been made clear that it is the case manager's responsibility to develop the POC. The CAP Procedures Manual clearly states, "Completion of the Plan of Care is your (case manager) responsibility" (page 43). Supervisors will direct case manager development of POCs with review by the Compliance and Monitoring Unit.

Although POCs should not be developed by providers, participation of the provider in developing the plan of care is valuable, as noted in page 10 of the CMS report: "DDD also encouraged providers to participate in the development of plans of care for CAP participants. This provided an excellent opportunity for providers to share valuable information with other people involved in the process as well as to learn more about client's needs and other services that may be available to the client."

Clearly the POC should be based on the skills, interests and needs of the client. This has been addressed through training on the CAP Procedures Manual, which requires the case manager to gather information, obtain input and develop goals by consulting with the

waiver participant. Supervisors will provide direction on this process and the Compliance and Monitoring Unit will monitor compliance with this requirement.

To ensure POCs are individualized, the CAP Procedures Manual instructs case managers to take the steps necessary to document the individual goals of the client. The POC Checklist (page 48) states that each goal must be clear, specific, observable and measurable with clear timelines and clear criteria for knowing when each goal has been achieved. Although the waiver does not indicate the POC must identify specific providers who would be providing waiver services, we agree that this information should be contained in the POC and by November 1, 2002 will modify the CAP Procedures Manual to include this instruction. Updated instructions reflecting this requirement will be provided to regional staff by September 1, 2002. Page 53 the CAP Procedures Manual indicates the review of the POC must take place at least annually. Supervisors will ensure the content and reviews of the POC meet waiver requirements and the Compliance and Monitoring Unit will monitor compliance. Periodic training will occur as will targeted training as requested by supervisors or noted as needed by the Compliance Monitoring Unit.

To ensure all assessed needs are addressed in the POC, staff training has been provided and the CAP Procedures Manual, states (page 44), "POC goals must be built upon this input from the waiver participant and those supporting them as well as formal needs assessment information. Document a reason anytime the POC does not include goals reflecting the waiver participant's assessed needs." In addition, the POC Checklist (page 48) reiterates these requirements. Monitoring and compliance will be the responsibility of Case Management Supervisors and the Compliance and Monitoring Unit.

The importance of health care has been recognized in staff training and in the CAP Procedures manual, which instructs (page 45) case managers to update medical needs and current medications when completing the POC. This item is also included in the POC Checklist (page 49). In addition, by November 1, 2002, the CAP Procedures Manual will be updated to indicate that the POC must contain information about the client's last physician or dentist visit as well as monitoring activities regarding the effectiveness of treatment regimens. Updated instructions reflecting this change will be provided to regional staff by September 1, 2002. If the individual (and/or the family) does not wish to visit a physician or dentist annually, this will be noted and any concerns about health and welfare will be discussed with the individual and/or family and documented in the POC. The lead role, to ensure compliance with these requirements, will be assumed by Case Management Supervisors and the Compliance and Monitoring Unit.

With respect to choice of providers, the CAP Procedures Manual instructs case managers to "Document that you assisted the person to make informed choices among all qualified providers" (page 45). By November 1, 2002 the CAP Procedures Manual will be updated by adding the following to the end of the preceding sentence, "…of needed services." During November 2002, regional staff will receive training on the updated CAP Procedures Manual. In addition, updated instructions reflecting this change will be provided to regional staff by September 1, 2002. The Compliance and Monitoring Unit will monitor documentation of informed choices, while supervisors will emphasize this requirement.

With regard to choice among waiver services, the CAP Procedures Manual, POC Checklist, includes the following item (page 48), "Written information regarding all available waiver

services and providers is supplied to the waiver participant and those who support him/her."

Additional funding provided by the Legislature supports the Division to meet the needs of individuals on the waiver. During the 2002 supplemental legislative session, DSHS received $8,550,000 from the Legislature to meet the service needs of CAP Waiver participants. This funding will be phased in beginning July 1, 2002 and as a result of the bow-wave CAP Waiver clients will receive $14,400,000 of services in SFY04 and beyond.

The CAP Procedures Manual indicates (page 46), "The POC must be approved and signed by the waiver participant or their designee, legal representative, and you [case manager]." This requirement is also in the Plan of Care Checklist (page 49). The revised Procedures Manual to be released November 1, 2002, will indicate that the POC must be approved, signed, and dated by the above. Updated instructions reminding regional staff of this requirement will be provided by September 1, 2002. Supervisors and the Compliance and Monitoring Unit will ensure that clients and their guardians/representatives have the opportunity to participate in development of the POC and that signature dates are included on POCs.

The November 1, 2002 updated CAP Procedures Manual will require all signature dates to accurately reflect the date of signature and instruct the case manager be the last one to sign the POC. Updated instructions reflecting this addition to the Procedures Manual will be provided to regional staff by September 1, 2002. Changes in the Procedures Manual will be followed by regional training sessions.

The Division Director will ensure updated instructions are provided to regional staff and that these changes are made to the Procedures Manual and training is provided after the Manual has been updated. Supervisors and the Compliance Monitoring Unit will follow-up on these requirements.

In addition, staff training on the CAP Procedures Manual will emphasize that, as indicated in the CAP Procedures Manual (page 45), each ISP participant's name and position with respect to the client must be listed on the Plan of Care. Monitoring and compliance will be the responsibility of supervisors and the Compliance and Monitoring Unit.

With respect to timeliness of POCs and assessments, the Division has directed regional staff to review all plans of care for waiver recipients and update any that are over one year old. The 2001 CAP Procedures Manual (page 50) states that a review of each waiver participant's continued need for ICF/MR Level of Care and a review of their Plan of Care must occur annually. "You [case manager] must complete a new Assessment – Current Support Needs Child or Adolescent/Adult annually so that CAP eligibility can be re-certified by the Regionally Designated QMRP." Oversight to ensure annual reviews of POCs and the need for ICF/MR Level of Care will be the responsibility of supervisors and the Compliance and Monitoring Unit.

Since sometimes the POC references other service plans, by November 1, 2002 language will be added to the CAP Procedures Manual requiring that a copy of any provider POCs referenced must be included in the file and the copy (ies) should cover the same time period as the CAP POC. Updated instructions will be provided to regional staff by

September 1, 2002. Supervisors and the Compliance and Monitoring Unit will ensure these requirements are met.

With respect to the POC review letter, by September 1, 2002 the Division of Developmental Disabilities will change the letter to a) ensure the client understands that if changes to the POC are necessary, we need to have a face-to face meeting and b) indicate no decision regarding the adequacy of the current POC will be made until we hear from the client. By November 1, 2002, the Division will review the CAP Procedures Manual and make any changes to the Manual necessary to ensure that information about client appeal rights is comprehensive and meets federal requirements. The current letter does not state the plan of care is required only to secure federal funding. As previously indicated the CAP Procedures Manual clearly indicates the client and/or his/her representative must sign the POC.

CMS staff were concerned that out-of-date and/or inadequate documentation reduces the ability of the Department to monitor the health and wellbeing of waiver clients. On the other hand, the review did not reveal specific instances where client health and wellbeing were observed to be compromised. Nevertheless, this is an area of concern for the Department and has been addressed via the CAP Procedures Manual, staff training, an increase in the number of case management staff, provider qualifications, quality assurance, and incident reporting. Critical roles will be played by Case Management Supervisors and the Compliance and Monitoring Unit. Our implementation of corrective action will give substantive as well as procedural assurance that health and safety are not compromised.

The CAP Procedures Manual addressed client health and welfare in a variety of ways. With respect to development of the POC, the Manual indicates (page 43), "The POC must address all assessed needs of the waiver recipient, not merely needs that can be addressed with waiver services." "Information about medical needs and current medications must be updated when completing the POC" (page 45). Emergency situations are addressed as follows (page 46), "The POC must identify 1) an 'other' (neighbor, relative, friend) who is designated to contact the Waiver participant in the event of a serious emergency (e.g., severe weather, earthquake)." These areas are also included in the POC checklist (pages 48-49).

With respect to monitoring of the individual, the CAP Procedures Manual clearly instructs case managers that, "You must monitor the Waiver participant's progress and be responsive to his/her changing needs throughout the period of CAP enrollment" (page 49).

During in-person POC meetings, the CAP Procedures Manual provides the "Quality Assurance Conversation" Form (pages 54-55) as a guide and for documentation of areas covered. The Waiver participant and their legal representative (if applicable) sign the form at the bottom. The form covers the following topics: Information, choices, receiving services, needs met, concerns resolved, satisfactions with providers, and treated respectfully.

Staff training, using the CAP Procedures Manual as a focal point, was provided to regional staff during the late summer and fall of 2001. The manual and the training have increased case manager awareness that issues around client health and welfare must be addressed in the POC and that the monitoring of client health and welfare must be documented.

With respect to client health and welfare, one of the areas of concern has been sufficient case managers. An additional 10 regional FTEs have been added in FY2002. By June 2003, using funding in the current budget, the Division will increase regional staffing by an additional 38 FTEs. This increase will enhance the ability of individual case managers to monitor the health and welfare of individuals on their caseload.

For other areas related to provider qualifications, quality assurance, and incident reporting, we believe we have or are developing adequate mechanisms to ensure health and welfare, which is supported by the reviewer's findings as contained on pages 3, 6, 7 and 13 of the report. In addition, the report identifies no specific instances where client health or wellbeing was observed to be compromised.

- **Residential Services Initiatives: "DSHS implemented a very strong licensure, inspection and enforcement program to protect the health and safety of CAP participants residing in group homes and adult family homes" (page 3).**

- **Regional Initiatives: "We found numerous examples where DDD regional offices had initiated innovative and effective quality assurance projects" (page 6).**

- **Incident Reporting: "The State's incident reporting system provided a very good tool for capturing data and monitoring staff work" (page 7).**

- **Providers of Waiver Services: "Our review showed DSHS did a commendable job in establishing standards for providers of CAP services. We also found the licensure, certification and other monitoring activities had proved effective in ensuring providers remained qualified and fulfilled their contractual obligations" (page 13).**

Recommendation 7. Evaluate the rationale used by DSHS to make case management staffing decisions and take the steps necessary to ensure the number of staff needed to effectively case manage the people participating in the CAP waiver are assigned to that function. The State also needs to ensure sufficient administrative support is assigned to the area of case management.

DSHS RESPONSE: The Department recommends that the phrase "evaluate the rationale used by DSHS to make case management staffing decisions" be eliminated. At this point further historical analysis will do little to further our attempts to adequately fund case management for individuals with developmental disabilities.

In 1997 and 1998, DSHS conducted a Workload Standards Study of case/resource management in the Division of Developmental Disabilities (provided June 14, 2002 under separate cover). This study documented how case/resource managers spend their time; established essential standards for complying with federal and state requirements; and measured the number of case/resource managers that are needed to meet the requirements. Based on this information, DSHS included in its 2001-2003 budget request to the Governor, a request for additional case managers including administrative and supervisory support. In 2001, the legislature provided funds for 48 additional case managers including administrative and supervisory staff to be phased in during FY 02 and FY 03.

DSHS is currently in the process of updating the workload standards study by tracking how case/resource managers, administrative support staff, and supervisors are currently spending their time, updating the essential standards based on new federal and state requirements, and measuring the gap between the number of authorized case managers, administrative support staff and supervisors and the number of case managers, administrative support staff and supervisors needed to meet the requirements. This update will be completed by October 31, 2002. DSHS plans to repeat this process once the new 48 case managers have been hired. The information provided from these updates will be used to develop budget requests to reduce or eliminate the gap between the current number of case/resource managers, administrative support staff and supervisors and the number needed to meet essential standards.

Finding/Issue. Not adequately staffing the case management function also resulted in DSHS compromising the integrity and validity of the assessment process and placing CAP clients at undue risks to their health and wellbeing.

DSHS RESPONSE: DSHS recommends that the phrase "and placing CAP clients at undue risks to their health and wellbeing" be deleted. Again, the CMS report specifically states that clients are at risk, but does not identify or document these people or provide documentation or observation concerning how client health and welfare are being compromised.

Recommendation 8. Implement procedures requiring timely and appropriate assessments. The procedures should address each of the problems identified in the finding on timely and appropriate assessments and contain instructions that will ensure the problems do not occur in the future. The procedures should also describe how a case manager can remove an ineligible person from the waiver.

DSHS RESPONSE: We agree that improvement is needed in completing timely and appropriate assessments. Nevertheless, the health and welfare of waiver recipients has been maintained. This review did not find specific instances where an individual's health and welfare was compromised.

Compliance with assessment requirements will be the result of staff training, an updated waiver procedures manual, and follow-up and monitoring. The CAP Procedures Manual (page 50) states that a review of each waiver participant's continued need for ICF/MR Level of Care and a review of her/his Plan of Care must occur annually. Supervisors and the Compliance and Monitoring Unit will have the lead responsibility to ensure these requirements are met.

Finding/Issue: Only one individual was allowed to continue to participate in the waiver because the case manager did not know how to remove the client from the waiver.

DSHS RESPONSE: The CAP Procedures Manual contains instructions and cites the forms used to remove an individual from the CAP waiver. (pages 51, 52) Per the reviewer, this problem was attributable to a single case manager and did not appear to exist elsewhere in the state. The individual identified received instruction in removing clients from the waiver.

Finding/Issue: We found 37 of the reevaluations were not completed within the required 12 months. The time elapsed between evaluations for the 37 clients ranged from 13 to 93

months. Twelve of the 37 individuals had to wait 48 months or longer for their reevaluations.

DSHS RESPONSE: The Division has instructed regional staff to review assessments for waiver recipients and complete a new assessment when the current assessment is more than one year old. Monitoring by the Compliance and Monitoring Unit and direction provided by supervisors will address this requirement.

Finding/Issue: The case where the person had to wait 93 months between assessments was especially egregious.

DSHS RESPONSE: Although it is true that assessments were not completed annually, services were adjusted to reflect changing needs. This situation reflects a documentation problem, not a service delivery problem. Agency documents indicate that the initial assessment, which was based on the client's self-reported needs, did not accurately reflect the support services she would require on a daily basis. She has received residential services since 1986 and began receiving Intensive Tenant Support services in 1991. As her service needs fluctuated, agency support was adjusted to meet those needs. Current Supported Living Services include: support to access medical care and monitoring of health care needs, financial assistance, support to hire own staff, assistance with physical therapy program and Range of Motion exercises, and support to engage in a wide range of community and recreational activities. With the addition of field staff, case managers will be able to document timely assessments. The Compliance Monitoring Unit will be able to monitor completion records. .

Finding/Issue: We could not determine the time period between one client's current and previous assessments because information necessary to make this determination was not available.

DSHS RESPONSE: The November 1, 2002 revised edition of the CAP Procedures Manual will remind case managers that all assessments must be signed and dated upon completion. Written instructions will be provided to regional staff by July 1, 2002 to ensure assessments are signed and dated. In addition, the Procedures Manual specifies (page 57) that CAP records must be retained in the file for five years. The Compliance and Monitoring Unit will monitor compliance with these requirements. Case Management Supervisors will have lead responsibility to ensure that these requirements are met.

Finding/Issue: Our review of DDD's needs assessment activities also revealed case managers sometimes relied on the clients' care providers to perform the required annual reevaluations. In these instances, the case manager would ask the provider to complete the assessment for a client. We were told that this practice was limited to those situations where the client was receiving one of the CAP waiver's residential services.

DSHS RESPONSE: Staff training in conjunction with the 200l CAP Procedures Manual (which indicates on page 50 that the case managers

must complete the assessment) will resolve this issue. It has been made clear to case managers that the completion of the assessment is their responsibility. The Compliance and Monitoring Unit will verify compliance with this requirement.

Finding/Issue: DDD personnel also informed us that case managers would often elect to copy and re-date a client's assessment for the previous year rather than spend time reevaluating the client.

DSHS RESPONSE: This issue has been addressed via staff training and the CAP Procedures Manual, which clearly indicates a <u>new</u> assessment must be completed annually. Case Management Supervisors will reinforce this requirement and the Compliance and Monitoring Unit will monitor compliance.

Finding/Issue: We were told case managers were assigned such high caseloads that it was virtually impossible for them to comply with the requirement for annual evaluations. DDD staff also stated the high caseloads encouraged case managers to rely on providers to do the reevaluations and elect to reuse previous assessments.

DSHS RESPONSE: An additional 10 regional FTEs has been added in FY2002. Beginning January 2003, using funding in the current budget, the Division will increase regional staffing by an additional 38 FTEs. This increase will enhance the ability of individual case managers to monitor the health and welfare of individuals on their caseload.

Finding/Issue: It also resulted in DSHS compromising the integrity and validity of the assessment process and placing CAP clients at undue risks to their health and wellbeing.

DSHS RESPONSE: The basis of this concern is that case managers were not completing their assessments. Insufficient case management staffing has affected the ability of staff to complete assessments in a timely manner. The addition of regional staff during the current and coming fiscal year, plus the staff the updated workload standards study indicates are needed, along with the CAP Procedures Manual and additional staff training, will enable the Division to fulfill its obligation to complete annual assessments. The addition of Compliance and Monitoring Unit staff will enable the Division to verify this requirement is being met.

Recommendation 9. Immediately discontinue the practice of using the Exception to Policy (ETP) process as a way for granting access to the CAP waiver. The State needs to return the $1,829,017 in federal funds claimed for CAP services and $750,060 in Medicaid State Plan services provided people with ETPs during our review period. The State also needs to determine the amount of federal funds claimed for waiver and State Plan services provided people with ETPs subsequent to June 30, 2001 and refund those monies.

DSHS RESPONSE: These recommendations are based on the discussion in the draft audit report about listings provided by the State showing that 275 (actually 278) people gained CAP waiver eligibility through exceptions to policy ("ETPs"). The report suggests that these exceptions allowed people who did not require the level of care provided in an

ICF/MR to enroll in the waiver, and estimates that individuals who received ETPs were provided CAP waiver services totaling $3,574,505 and State plan services totaling $1,455,603. The report recommends that the State return the federal share of these amounts, which is $2,575,077.

The recommendations, both about the refund of FFP and about discontinuing the practice of using the ETP process, should be withdrawn because they reflect a misunderstanding about the ETP process and about the types of exceptions that were made through ETPs. The role of the ETP process is described in the State's CAP Procedures Manual. With respect to ICF/MR level of care, use of this process is a routine component of policy, reflecting a recognition that any standard overall level-of-care assessment instrument does not necessarily cover every individual circumstance that must be considered in determining whether a person needs ICF/MR level care.

Attachment D-3-a of Washington's approved CAP waiver describes the process and criteria used to establish the need for the level of care provided in an ICF/MR. This CMS-approved process includes, in addition to the level of care assessment score, the use of "other available supporting information" to determine the need for ICF/MR level of care. It is reasonable to assume the assessment instruments (one for children, the other for adolescents and adults) are not applicable (i.e., do not adequately address all needs) to a few individuals who will require a second level of review, which is why "other supporting information" language was included in the waiver. DSHS used the Exception-to-Policy (ETP) process to document the need for ICF/MR level of care but not to grant an exception to the requirement that all waiver recipients must require ICF/MR level of care.

ETPs were granted in the case of individuals whose assessment scores did not clearly indicate the need for ICF/MR level care, but as to whom further review by professional staff indicated functional limitations qualifying the individual for this level of care. The DSHS CAP Manual describes this routine practice:

> **When the SW [social worker], CRM [case resource manager], or QMRP [qualified mental retardation professional] determines that an individual does not appear to require an ICF/MR Level of Care according to the scoring of the support needs assessment, yet they believe there may be other factors affecting the individual's level of need, they may request an ETP . . . through the usual regional procedures.**

See CAP Procedures Manual: A "Work in Progress," 2001 at page 37 (emphasis added).

Internal correspondence from DSHS to CAP Waiver Coordinators further explains that an "ETP is not an exception to the ICF/MR level of care requirement." Memorandum (provided under separate cover) from Dave Langenes, Division of Developmental Disabilities to CAP Waiver Coordinators, May 22, 1998 (emphasis added) . Instead, ETPs "represent an exception to the requirement of the specified score on the Current Support Needs Assessment." Id. In each of these cases, the "ETP should include a description of the individual's need for ICF/MR level of care." Id.

Washington's use of ETPs as a way of using additional information to determine ICF/MR eligibility is allowable. There is no reason for the State to discontinue using the ETP

process, because, as the CMS-reviewed and endorsed report entitled Understanding Medicaid Home and Community Services: A Primer ("Primer")[1] notes, states may use different evaluation processes for determining eligibility for HCBS waiver services than for institutional placement. Primer at 61 n.17.

ETPs are also used to waive discretionary State policies, which do not relate to ICF/MR level of care. The discretionary State policies to which exceptions are made, and were made during the period that the auditors reviewed, are not federal level-of-care requirements or other federally mandated criteria for waiver participation. The discretionary State policies that were waived are contained only in the DSHS CAP Procedures Manual or in internal agency memoranda, not in any State law or regulation.

As an example of the use of the ETP process to waive State discretionary policy, the State's CAP Waiver Manual states that eligibility verification tasks are to be completed within 90 days after an applicant applies for waiver enrollment. ETPs have been issued in some cases in which not all of the required eligibility verification tasks were completed within 90 days. While completion of these tasks within 90 days remains a goal, it is within the State's authority to waive this requirement when it undermines the legitimate goals of the waiver. There is simply no basis for disallowing FFP because the process is used from time to time.

Other examples include exceptions to internal division policies relating to annual physician statements or certifications or priorities around cost of care. These internal policies are separate from waiver requirements or rules.

There is no authority for disallowing FFP on the ground that the ETP process has been used as described above or that internal policies have been waived or changed. The law is clear that policies stated only in internal agency operating manuals (such as the DSHS CAP waiver manual) do not have the force of law. See Valen Mfg. Co. v. United States, 90 F. 3d 1190 (6th Cir. 1996) (internal operating manuals do not carry the force of law and are not binding). Moreover, DSHS has the authority to waive its administrative requirements. Therefore, the fact that DSHS made exceptions to its own administrative procedures and policies does not justify a disallowance. See Ohio Department of Health and Human Services, DAB Decision No. 725A (1986) (reversing a disallowance based on State's failure to follow its own policy).

> Finding/Issue: We also found a number of the people included in our sample did not require the level of care provided in an ICF/MR. The documentation confirmed that most of these people were placed on the waiver to capture Federal Financial Participation (FFP) for the cost of services that would have otherwise been the sole responsibility of the State.

---

[1] **This report is available at www.aspe.hhs.gov/daltcp/reports/primerpt.htm. The report was prepared by the George Washington University Center for Health Policy Research to answer questions about "what is allowable under Medicaid law and regulation" pertaining to home-and-community based waivers. *Primer* at 1. "Every chapter" was reviewed by CMS staff for "technical accuracy." *Id.* at 2.**

DSHS RESPONSE: Although the information in some ETPs may not have clearly indicated the need for ICF/MR level of care, as explained above, all individuals enrolled in the waiver during the review period did require ICF/MR level of care.

Finding/Issue: The listings we received showed 275 people gained CAP eligibility through ETPs.

DSHS RESPONSE: As explained above, of the 275 (actually 278), to date we have reviewed 251 individual files. (matrix provided under separate cover). **Of the 251 individuals, all require the level of care provided in an ICF/MR. The review of the remaining 27 individual files is not complete. The department agrees to return the funding used for any of these people who do not meet ICF/MR level of care criteria or we will update the matrix and provide the information. The reviews will be completed by July 10, 2002.**

Finding/Issue: Many of the approved ETPs were requested solely for the purpose of allowing the person access to CAP services. The CAP waiver was used as a vehicle to gain access to regular Medicaid services because the waiver offers Medicaid eligibility to non-institutionalized individuals with higher incomes than allowed under the State's regular Medicaid program.

DSHS RESPONSE: Please see response above. In addition, by federal rule, individual or family income may NOT be used to prevent eligible individuals (including children) from choosing ICF/MR Medicaid services. It is not logical to make income an issue for eligible persons who choose community Medicaid service alternatives through the waiver thereby potentially forcing them to choose a more expensive ICF/MR service in order to get their health and habilitative service needs met.

Recommendation 10. Take immediate steps to resolve the problems inhibiting CAP clients from receiving due process. Policies need to be implemented ensuring written notifications of denials are issued and fair hearings are not unnecessarily delayed. Policies also need to be implemented prohibiting DSHS from appealing default decisions granted because DSHS personnel failed to appear at the hearing.

Finding: We examined four cases where the client requested a fair hearing. In all four cases, we found DDD had complied with applicable CAP waiver requirements and followed DSHS procedures.

Finding/Issue: The use of oral notification proved problematic in one of the cases reviewed.

DSHS RESPONSE: Since the current waiver states persons who are denied the service or provider of their choice are verbally notified of their right to a fair hearing, this was not a violation of the waiver. Nevertheless, we agree that it will be a cleaner process to provide, in the future, written notification of a denial of service. This will be addressed as follows: A written notice informing clients of the denial of requested services, the reason for the denial, and the right to request an administrative fair hearing and the manner

by which a hearing may be requested will be developed and implemented by November 1, 2002 and included in the updated CAP Procedures Manual.

Finding/Issue: Three of the cases reviewed involved fair hearings where state personnel failed to appear for the scheduled hearing. State staff failed to appear at hearings in 3 out of 4 cases and caused a number of other delays. This strongly suggests the fair hearing process was given relatively low priority; otherwise, steps would be taken to ensure staff met their obligations. According to the reviewer, in one case, the hearing was canceled at the last minute because the DDD representative was ill. In the two other cases, the hearing officer issued an order of default granting the client relief.

DSHS RESPONSE: A review indicated that we have taken steps to develop a process that makes every effort to have staff available for scheduled hearings. Two headquarters staff persons track all administrative hearings and coordinate with regional staff to ensure hearings are covered. Each region has a fair hearings coordinator to represent the division in administrative hearings. When additional support is needed, the division obtains representation in hearings by the Attorney General's Office.

The Office of Administrative Hearings (OAH) conducts administrative hearings. OAH is not part of DSHS and the division has no control over OAH's scheduling of hearings. In most instances, OAH schedules hearings within 30 days of receiving the hearing request. Occasionally the hearing date must be changed due to scheduling conflicts on the part of the appellant or Division staff. In rare cases, the hearing date is cancelled or rescheduled due to unexpected illness of either the appellant or the Division staff or in more complex cases due to pre-hearing discovery or settlement negotiations. Such continuances are governed by OAH and granted only for good cause.

The two hearings that resulted in a default order were caused because the regional fair hearings coordinator did not receive notice of the hearing date. The division moved to vacate the default order with good cause, and both fair hearings were reinstated by OAH. Both hearings were dismissed at the appellant's request. We have done a review of statistics kept since 2000, of 301 requests for hearings since January 2000, the department did not appear in 3. The only two cases that have gone into default are the ones noted in the CMS Report. There was one additional instance in which a Division representative failed to attend the fair hearing. In each instance, the notification process failed. The division has modified its procedures to ensure that all regional staff are promptly notified of fair hearing dates to ensure these rare instances are not repeated. Headquarters staff now send copies of all fair hearing notices to the Regional Fair Hearing Coordinator. Previously it was assumed the OAH was forwarding copies to regional staff, which turned out not always to be the case.

Recommendation 11. Establish policies preventing the claims payment problems identified in the report from recurring. The State also needs to conduct an audit of its Social Service Payment System and determine: the dollar amount of payments made for waiver services provided during periods in which paying for waiver services at rates in excess of the rates specified in the provider's contracts; the

overpayments attributable to paying providers for waiver services on a different basis than allowed in their contracts; and, the amounts spent for waiver services not supported by an invoice. The audit should cover the entire period of July 1, 1997 through June 30, 2002 and provide statistically valid projections of the overpayments attributable to each of the four problematic areas. The State should also determine the Federal Financial Participation involved in the overpayments and refund those monies to the Federal government.

DSHS RESPONSE: The draft audit report states that a number of contracts had effective dates that preceded the dates on which the contracts were signed. The auditors also found that in a handful of cases, waiver providers were paid rates higher than those specified in their contracts or were paid on a basis different from that specified in the contract. The report suggests that these contracts and cases are associated with "overpayments" for which the FFP should be repaid.

This recommendation, too, should be withdrawn. There is nothing inappropriate about contracts whose effective dates precede the date the contracts were executed. Washington state law permits parties to enter into enforceable contracts with retroactive effective dates. Furthermore, nothing in the Medicaid statute, regulations, or CMS guidelines prohibits the use of retroactive provider agreements. Quite the contrary, Medicaid regulations specifically recognize that Medicaid provider agreements may be retroactive. See 42 C.F.R. § 431.108(d)(2) (providing for provider agreements with nursing facilities to be retroactive for up to one year).

As to the cases in which the basis for payments differed from the contract unit of payment (e.g., payment on a monthly rather than hourly basis), the service was delivered and the provider was paid the appropriate amount. The difference in the payment is an artifact of the system where some services may be paid at <u>either</u> an hourly <u>or</u> monthly rate.

Finally, no issue has been raised about the reasonableness of the provider payments in question, or about failure to comply with any term of the State's approved waiver. The waiver does not specify payment rates, and "there is no Federal rule that all services must be paid based on hourly rates." Primer at 169. In sum, the audit findings on this point do not justify any disallowance or warrant any repayment of FFP.

Finding/Issue: Nine of the contracts had effective dates that preceded the dates the contracts were signed. The period elapsed between the effective dates and the signature dates ranged from 7 to 274 days. This indicates the State may have made payments to providers for services rendered during periods in which the provider did not have a valid contract.

DSHS RESPONSE: Because some eight (not nine) contractors began providing services prior to the dates written contracts were executed, CMS believes that payments to such providers should be disallowed because they lacked a "valid" contract with the Division. However, in no case was a provider paid to provide services without first entering into a contract with the Division consistent with 42 U.S.C. § 1396a(a)(27) and 42 CFR 431.107(b). While in some cases there was a delay in executing a written contract, the Division entered into valid and binding oral contracts with the providers prior to authorizing services. The Division completed a

background check or otherwise knew the provider, made sure the provider was qualified, and only then authorized the service.

When establishing a working relationship with a provider, who will be providing waiver services to CAP participants, state and county staff spend a great deal of time, mostly face-to-face, with the potential provider. Topics that are discussed include provider responsibilities; state/county expectations; reimbursement and billing process; policies; procedures; background check rules; contract process; services delivery values; consumer rights; and client services.

While it is important to have a written contract process, it is crucial to be able to respond to emergent client needs. Clients living in remote communities with one or few providers might need to abruptly change providers based on an emergent change of circumstances. The health and safety of the client might rely on the responsiveness of a provider not currently under contract. Another example affecting the execution of contracts is with state/county contracts. The State contracts with the counties, who then subcontract with employment/day program providers. These subcontracts are affected when the legislative budget bills are not enacted until late spring or early summer. Thus, although the State agrees that ideally written contracts should precede the delivery of services, we do not believe it would be consistent with the goals of the Medicaid program or of the CAP waiver for the State to adopt contracting policies that would prevent the State from being responsive to client needs.

The Division disagrees that payments should be disallowed, as the State's records document that all payments were made for services actually rendered to eligible recipients.

Finding/Issue: Two instances where the provider was paid an hourly rate higher than specified in the provider's contract; one claim where the provider payment was based on a monthly rate while the contract stated the provider was to be paid on an hourly basis; and one case where the provider received a payment without submitting an invoice.

DSHS RESPONSE: There is no basis for this disallowance. Providers were paid the amount specified by contract. There is no evidence that payments were made in excess of the contracted amount. Two payments were made using a monthly rate while the contract contained an hourly rate. This does not mean services were not provided or the payment was inappropriate. Certain one-time payments can be made in the Social Services Payment System (SSPS) without submission of an invoice. In those cases, regional staff obtain documentation that the service was provided or the equipment was delivered.

The Division disagrees that payment should be disallowed, as the Division only paid for services that were actually performed and the services were paid at the rate authorized by contract.

Finding/Issue: DSHS should be able to determine the exact cause of the contracting and claims processing problems, ensure corrective action is taken to resolve the problems and determine the overpayments and associated federal financial participation associated with the various problems.

DSHS RESPONSE: There is no statutory or regulatory basis for a disallowance. As indicated above, the audit findings do not justify any disallowance or warrant repayment of FFP.

Recommendation 12. Implement procedures to prevent the costs of childcare services and other services not included in the CAP waiver service definitions from being charged to the waiver. The State also needs to refund the FFP inappropriately claimed for childcare to the Federal government.

DSHS RESPONSE: DSHS agrees and corrective action has already been taken. As indicated to CMS staff during their review of the CAP Waiver, expenditures for childcare services provided prior to January 1, 2002 are being backed out of the claim. A request to change the accounting system to no longer claim FFP for VPP-child care services was submitted March 19, 2002. The change was effective for services provided on or after May 1, 2002. Additional codes were removed this month.

Recommendation 13. Immediately discontinue extending CAP waiver participation to individuals who gain Medicaid eligibility through the provisions of 42. CFR 435/217 but do not receive a waiver service. The State needs to refund the $28,549,755 in federal funds inappropriately spent on Medicaid State Plan services provided to similar people after June 30, 2001, and refund the Federal share of the payments

DSHS RESPONSE: The draft audit report charges the State with "allow[ing] a significant number of people to remain on the CAP waiver even though they did not receive a waiver service." See Draft Audit Report at 19. The report recommends that the State refund the FFP associated with the costs of providing basic Medicaid services to individuals who "did not receive a waiver service in two consecutive months or within 30 days from the date they were enrolled in the waiver." Id. At 19-20. The report states that the FFP associated with State plan services provided to these individuals is $28,549,755.

Washington has two (2) primary codes that it uses to cover Waiver participants. Code N covers SSI CNIL and Code J covers SSI CNIL, <SIL or 217 (c) recipients. In the documentation provided to WA to disallow claims, the people cited were included in the N category in ACES. There were no recipients in the provided documentation who were categorized using the J or 217 (c) code.

According to CMS all of the people in the N category fit the 300% of SSI income standard. That assumption is not correct. In the time allotted Washington was able to review the FY2000 information that CMS used to make this claim. There were 969 people in that claiming year who also received a Supplemental Security Income payment. The assumptions in the Report with regard to this Recommendation are incorrect.

Further from a program standpoint, The recommended disallowance is not based on any provision of law and is flatly contrary to CMS policy. There is no statutory or regulatory requirement that a waiver client receive waiver services within any specified timeframe. Likewise, no CMS policy statement has given states notice of such a policy (which would be contrary to the statutory intent and thus invalid even if it were announced). As the HHS

Departmental Appeals Board (the "Board" or "DAB") has ruled repeatedly, disallowances premised on violations of cited agency policies where the policies "were not clearly adopted by the relevant program office, were not consistently applied, and were not appropriately communicated to states" will not be upheld. See, e.g., North Carolina Department of Human Services, DAB Decision No. 1631 (1997).

Not only has CMS failed to articulate and systematically communicate to the states the 30-days-after-enrollment and 60-consecutive-days policies on which the draft audit relies, but DSHS information is that some CMS Regional Offices have in fact resisted State-initiated efforts to apply such restrictions. In light of such inconsistent CMS policies regarding use of waiver services, a disallowance cannot be justified on the basis of the 30-days-after-enrollment and 60-consecutive-days policies cited in the draft audit report.

Moreover, for the auditors to use such a purported standard, indicates that they seriously misapprehend the Medicaid HCBS waiver program. It is no accident that there is not a uniform federal standard about the time within which waiver services must be used. The extent of utilization of waiver services is expected to vary from state to state because of the wide differences among states in the services already covered under the State plan. See Primer at 89-90. States such as Washington that include many children in their waiver predictably will have lower utilization of waivers services, as a result of the fact that, under the federal EPSDT mandate, a full array of services - whether or not they are covered under the State plan - must be made available and can meet many of the needs that would otherwise be met through waiver services.[2] See Primer at 90 (noting that waivers that principally serve children usually offer fewer services than programs that principally serve adults with disabilities). A manifestly unfair "Catch-22" would be created if the State's compliance with the EPSDT mandate, and the associated decrease in utilization of waiver services, were allowed to disqualify the State's claim for FFP.

An analysis of the CMS Report data supports Washington's position. The majority of waiver clients in question did in fact receive numerous State plan services consistently throughout the year. For example, it was very common for participants to receive State Plan services every month. Indeed, of the $28 million that the draft audit report recommends should be disallowed, services to waiver enrollees who received State Plan services every month accounted for over $22 million. Furthermore, over $3.5 million was spent providing services to waiver enrollees who received State Plan services in ten or eleven months of the year. Waiver enrollees who received such frequent State Plan services were clearly in need of substantial medical care, which they would have received had they been institutionalized. Their receipt of State Plan services, at the cost of $25.5

---

[2] **It is the enrollment of children, not primarily of adults under the 300 percent option, which accounts for the pattern of waiver utilization that the audits observed. But even if the State had taken full advantage of the 300 percent option to broaden Medicaid eligibility, there is still nothing inappropriate. The CMS-endorsed *Primer* encourages such a strategy, recognizing that the "waiver approach is advantageous in that states can broaden eligibility by using the 300 percent of SSI rule to each person in the community who would not ordinarily meet the financial qualifications for Medicaid." *Primer* at 105. To the extent that tacit disapproval of this approach underlies the recommended disallowances, the recommendation clearly is unfair and should be rejected.**

million over a four-year period, contributed to their ability instead to remain in the community, enabling the federal government and the State to avoid the costs of institutionalization. The federal share of the cost of institutionalization over a four-year period for these same recipients would have been in the neighborhood of $100 million. There is no justification for CMS to demand repayment of the far lower amount expended on State Plan services for these and other waiver enrollees

It may be that many individuals who have been deinstitutionalized and returned to the community can be expected to utilize waiver services within the 30 or 60 days that the draft audit uses as a rule of thumb. That is because these individuals "frequently lack adequate networks of informal and community supports (a lack that led to their institutionalization in the first place)." Primer at 115. But no such standard should apply for individuals who, while they would otherwise need institutional-level care, are able to avoid institutionalization in the first place and can do well with infrequent use of waivers services because of other care arrangements available to them. See Primer at 138 ("Access to informal care clearly helps individuals remain within their homes and communities."). Such individuals do not become ineligible for waiver services because they are fortunate enough to enjoy these benefits. As the Primer recognizes:

> **[F]amily members who have previously been providing services do not significantly decrease their efforts when publicly funded services become available. . .. Medicaid-funded home care programs serve both individuals who receive substantial amounts of informal care from family members and individuals who are almost entirely dependent on formal services. . . . Federal policies present no substantial barriers to states in using Medicaid dollars to support people with substantial functional limitations who live with their families (and thus, by definition, have access to informal care). . . . Thus, home and community services can be furnished to individuals who live with their families or in their own home just as readily as to individuals who are served in formal living arrangements such as group homes or assisted living. . . . Nor is there any stipulation that services may not be furnished if an informal caregiver is present. . . . Federal policy allows and encourages the "best practice" of matching home and community services to the unique needs of individuals and the circumstances of their informal caregivers.**

Primer at 139-40 (italics added). Indeed, some states' waivers "have been crafted principally to meet the [limited] needs of individuals who live with their families or on their own with informal caregiving available to them." Primer at 148. The draft audit report recommendations relating to use of waiver services are entirely contrary to these policies (and the sometimes-very-limited-or-infrequent use of waiver services they permit) and should be rejected.

CMS policy is to permit States such as Washington to encourage family members to provide home-based services to developmentally disabled clients, even at the cost to the federal (and State) government of the clients' State plan services, because the alternative would be that the federal (and State) government would bear the cost of both home-and-community-based-services paid for through the waiver and State plan services. Non-use of waiver services during a period does not mean that waiver participants do not need

waiver services or do not require an ICF/MR level of care. As the Primer states, "many people who meet level-of-care criteria will remain in the community, even without formal services." Primer at 59. It means instead, that in Washington there is a strong network of family support. There is nothing inappropriate about waiver enrollees' reliance on State plan services that reduces their needs for services through the waiver. CMS has specifically recognized that the extent to which other State plan services meet the needs of waiver enrollees will have an effect on utilization of waiver services. See Primer at 19. The agency has acquiesced in the view that states should develop their level-of-care and waiver-service criteria "with an eye toward the full constellation of services and supports" available in the state. Primer at 60 ("the criteria should fit together so that all individuals needing long-term-care services in the state are able to obtain the particular services appropriate to their needs").

A policy purporting to impose a deadline by when waiver services must be used for a waiver participant to remain within the program is particularly inappropriate as applied to a waiver, such as Washington's CAP waiver, that covers respite services. "[S]ince respite is intended to renew the energies of the caregiver (for the direct longer term benefit of the beneficiary), its use should be determined mainly by caregivers." Primer at 144 (also noting that "States have the option to permit 'banked respite' to be carried over from one year to the next," meaning that the service remains an entitlement even though it may not be used at all during a given year). As to other waiver services as well, it is a permissible option under a waiver for individuals and families to "select the services they want" -- a policy that necessitates permitting an enrollee to choose to receive no services over an extended time period. See Primer at 150.

Other waiver services, such as environmental modification, very clearly are not needed on a monthly basis or at other frequent intervals. The 30- and 60-day time periods utilized by the auditors as the basis for their findings are arbitrary and capricious as to many types of waiver services. These standards also conflict with the regulatory time frame (one year) for reevaluation of an enrollee's need for services. See 42 C.F.R. § 441.302(c)(1)(ii).[3] In conducting reevaluations, the State is to determine whether a recipient "might need [institutional] services in the near future (that is, a month or less) unless he or she receives home or community-based services" Id. § 441.302(c)(1). Furthermore, the regulation's use of the tentative term "might" negate any argument that there is a fixed standard time within which services must be needed and used.

Washington's CAP waiver also covers "extended State plan services" (including physician, physical and occupational therapy, speech/hearing/language, behavior therapy, prescription drug, and other services), i.e., . services that are covered under the State plan, albeit in lesser amounts, duration and scope than are available under the waiver. As noted in section 4442.3(A) of the State Medicaid Manual, the amount chargeable for waiver services is that amount "incurred after any limits in State plan services have been reached." The reason why many waiver enrollees did not utilize a waiver service during the period under review is that they had not exhausted their State plan services. This is not surprising given the relatively generous benefits offered under Washington's State

---

[3] **In addition, CMS Form 372(S) instructs that "[t]o be reported as a waiver recipient, the individual must have received a waiver services during the [annual] reporting period for which Medicaid payment was made."**

plan. The pattern of waiver-service usage may be different in states that offer less generous State plan coverage, but Washington should not be penalized because of the level of coverage offered under its approved State plan.

Moreover, as the draft audit report notes, waiver enrollees received some services covered under the waiver, such as environmental modification, for which the State failed to bill. Draft Audit Report at 17. Thus, the data about non-use of services is not fully representative of the level of usage. In addition, the utilization of services is affected by the fact that Washington does not cover case management under the CAP waiver but performs administrative case management for waiver enrollees. If case management were included in the waiver, every enrollee would have utilized a waiver service during the time periods under review. The State should not be penalized for how it has exercised its discretion about how to allocate needed services between the waiver, Medicaid administration, and the State plan.

For all these reasons, the recommended disallowance pertaining to use of waiver services is ill founded and should be rejected. For the same reasons, the State rejects the recommendation that it "immediately discontinue extending CAP waiver participation to individuals who gain Medicaid eligibility through the provisions of 42 CFR 435.217 but do not receive a waiver service." Again, there is no timetable by which an individual waiver enrollee must receive a waiver service. What is required under section 435.217(c) is that "the group receives the waivered services." The group covered by the CAP waiver, developmentally disabled individuals who require ICF/MR level care, is receiving waivered services at any given point in time, so the regulatory requirement is satisfied.

Finding/Issue: Our analysis of the data produced by the SSPS and MMIS showed DSHS had allowed a significant number of people to remain on the CAP waiver even though they did not receive a waiver service. These people continued to participate in the waiver because DSHS incorrectly applied the provisions of 42 CRF 435.217.

DSHS RESPONSE: See the discussion above. While some individuals enrolled in the waiver did not receive waiver-funded services during certain months under review, all received periodic waiver services. There is no required time by which a waiver participant must receive a waiver service. At any given point in time, members of the waiver target group are receiving waiver services, so the requirement of 42 C.F.R. 435.217(c) is met.

Finding/Issue: We found DSHS considered only two of the three requirements contained in 42 CRF 435.217 when determining a person's eligibility for CAP participation. DSHS failed to ensure individuals met the third requirement of actually receiving waiver services. We considered a person not eligible if he or she did not receive a waiver service in two consecutive months or within 30 days from the date they were enrolled in the waiver.

DSHS RESPONSE: See the discussion above. DSHS did not fail to consider and apply all of the requirements of 42 C.F.R. 435.217. The third requirement -- "the group receives the waivered services -- is met because, at any given point in time, members of the waiver target group are receiving waiver services. There is no statutory or regulatory basis for the 30-day and two-month standards that the auditors employed, and no published CMS policy statement purports to impose such a standard.

Finding/Issue: Information gathered during our data validation suggests people who did not require CAP services were enrolled in the waiver to obtain FFP for services that would otherwise have been funded entirely with State monies.

DSHS RESPONSE: See the discussion above. All individuals enrolled in the waiver require CAP services and all eventually use CAP services. Nonetheless, the frequency of usage varies depending upon the type of service utilized (for example, day program vs. respite) and the degree of supportive services provided by family members. Individuals receiving extensive family support or extensive State plan services that minimize their need to access waiver services are not disqualified from waiver participation.

Recommendation 14. Refund the $2,438,636 in FFP claimed for waiver services provided those individuals who comprised the group of 1811 excess enrollees in year 3 of the waiver. The State should also refund the $110,379 in FFP claimed for Medicaid State Plan services provided those individuals in the group who gained Medicaid eligibility through 42 CFR 435.217.

DSHS RESPONSE: The draft audit report states that DSHS extended waiver participation to **11,788 individuals during this year even though the approved waiver limited participation to 9,977 people. The report states that the 1,811 additional clients received waiver and State plan services for which the costs were unallowable and for which the State received a total of $3,549,015 in FFP. The report recommends that the State be required to repay this amount since it did not submit a waiver amendment request seeking approval for the additional 1,811 participants on or before the last day of the waiver year.**

Like the other findings about recommended disallowances, this finding should be rejected. There is no basis for treating a state's approved waiver enrollment for a year as the type of limit that justifies denial of FFP when it is exceeded.

Section 4442.8(C) of the State Medicaid Manual does state that a State's "estimated annual unduplicated number of individuals who are expected to receive home-and-community-based services" under a waiver "constitutes a limit on the size of the waiver program." Other guidance makes clear, however, that this reference to a limit means that the approved enrollment is a shield for the State, not a sword to be used by CMS to justify a disallowance when the estimated enrollment is exceeded. As the Primer recognizes, limits on waiver enrollment "enable states to control utilization and overall outlays." Primer at 59.[4]

---

[4] **DSHS recognizes that section 4445(B)(2)(a) of the *Manual* -- which does not have the force of law -- states that a "change in the number of waiver recipients served" would constitute a substantive amendment in a waiver that either "usually must be approved by HCFA prior to the implementation of the proposed change" or "may be approved with a retroactive date as far back as the beginning of the waiver year in which it is submitted." *State Medicaid Manual* § 4445(B). However, this language appears to be a hold-over from the days when the so-called cold bed rule was still in effect, when an increase in waiver enrollment had to be justified by data about available beds, and when HCFA assumed**

Although States are authorized to limit waiver enrollment, they have been given "the go-ahead to expand their HCBS waiver programs to whatever level they desired." Primer at 147. (This is consistent with CMS' emphasis on the Supreme Court's Olmstead ruling.) "Each state may establish whatever limit it chooses and may change its limits whenever it wishes." Id. at 166. "A state may change this maximum number [of waiver beneficiaries] at any time by notifying HCFA of the change." Id. at 164. Further, section 4442.8(C) of the Manual also states that the limit on the size of a state's waiver program "may be revised through an amendment request when you determine you need to increase or decrease the number of individuals you will serve under the waiver" (emphasis added). Similarly, in the preamble to July 1994 amendments to the HCBS waiver regulations, HCFA stated that a state's estimate of the number of unduplicated waiver recipients to be served each year "may be revised as a State deems necessary." 59 Fed. Reg. 37712 (July 25, 1994) (emphasis added).

Further, in its 1988 notice of proposed rulemaking pertaining to HCBS waivers, HCFA emphasized that the number of individuals receiving services under a so-called model waiver "at no time . . . may . . .exceed the specified number approved." 53 Fed. Reg. 19957 (June 1, 1988). By contrast, HCFA said the following about HCBS waivers: "States are expected to stay within their [utilization] estimates and should request HCFA approval of an amendment of their waiver estimates when they exceed those approved, whether this is due to high turnover or other factors." Id. (emphasis added). And in a July 25, 1994 rulemaking preamble, acknowledging that "data regarding program utilization will no longer be relevant to the waiver application process," HCFA noted its belief that a state "should be required to submit amendments to explain the basis and extent of the changes" to waiver utilization, substantiating continued cost neutrality. 59 Fed. Reg. 37702, 37708 (emphasis added). The "expected to" and "should" language quoted above clearly indicates that a state's approved waiver enrollment limit is not an absolute one that triggers fiscal penalties. See Tubelite Architectural Products v. United States, 706 F. Supp. 46, 48 (Ct. Intl. Trade 1989) (the use of "should" rather than "shall" conveys an expected format that is precatory rather than mandatory). Such non-mandatory language cannot support a disallowance action Cf. Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1 (1981) (conditions on the grant of federal funds must be stated unambiguously).

Each of the policy statements quoted above indicates clearly that the number of waiver recipients is discretionary with the State, consistent with the congressional intent "to

---

that waiver expenditures that exceeded estimates could be the basis for a disallowance. *See* 50 Fed. Reg. 10013 (1985).

In 1986, Congress amended section 1915(c) of the Social Security Act to bar CMS from denying FFP on the ground that total waiver expenditures exceeded a state's estimate. *See* 42 U.S.C. § 1396n(c)(6). Since an increase in the approved number of waiver recipients could be one factor causing total waiver expenditures to exceed the estimated amount, Congress' action (which was followed in 1994 by HCFA's elimination of the cold bed rule) should be taken as an indication that CMS may not deny FFP in waiver expenditures for enrollees who exceed the approved number.

enable states to provide Medicaid waiver services to the maximum number of individuals for whom it would be cost-effective." Florida Department of Health and Rehabilitative Services, DAB Decision No. 1096, citing Pub. L. No. 99-272, § 9502 (1985).[5] CMS does not have veto power over the State's decision-making in this regard. In addition, no law prohibits CMS from retroactively approving an increase in a State's waiver enrollment, as far back as necessary. Given these facts, it would be an abuse of discretion for CMS to refuse to give retroactive approval for the 1,811 enrollees in issue here, and instead to announce a disallowance. See Iowa Department **of Human Services, DAB Decision No. 1340 (1992), in which the Board ruled that where (as here) no law prohibits the agency from issuing retroactive approval, and (as here) there are no substantive reasons that could justify disapproval, it is an abuse of discretion for the agency to withhold its approval on the ground that the request was not made by a specified time. Id. at 3 ("where an HHS agency has authority to grant approval after-the-fact, the agency may not merely rely on the lack of prior approval per se to deny retroactive approval; the agency must articulate a reasonably persuasive substantive basis for denying such approval"); see also Cincinnati-Hamilton County Community Action Agency, DAB Decision No. 771, at *5 (1986); Kuakini Medical Center, DAB Decision No. 1242, at *8 (1991).**

Since the decision to increase the number of waiver enrollees is discretionary with the State and since CMS did approve an enrollment increase for subsequent fiscal years, there is no "reasonably persuasive substantive basis for denying such approval" now. Iowa at 3. CMS should give retroactive approval and reject the draft audit recommendations. In the event that CMS takes the position that approval for the enrollment increase was required, the State hereby requests retroactive approval.

There are additional reasons why the recommended disallowance relating to excess waiver enrollment should be rejected. The waiver regulations contain a section (42 C.F.R. § 441.310) entitled "limits on Federal financial participation," that specifically addresses the circumstances under which FFP is not available. The regulation does not state (and no other regulation states or implies) that FFP is unavailable for expenditures for waiver services provided to waiver enrollees exceeding the approved number. Under the maxim of statutory construction "expressio unius est exclusio alterius," this omission should be presumed intentional. **Therefore, under the regulations, FFP is indeed available for these waiver services. See Botosan v. Paul McNally Realty, 216 F.3d 827, 832 (9th Cir. 2000) ("The incorporation of one statutory provision to the exclusion of another must be presumed intentional under the statutory canon of expressio unius."); United States v. Crane, 979 F.2d 687, 691 n.2 (9th Cir. 1992) ("The maxim of statutory construction, 'expressio unius est exclusio alterius' provides that '[w]hen a statute limits a thing to be done in a particular mode, it includes the negative of any other mode.'") (quoting Botany Worsted Mills v. United States, 278 U.S. 282, 289 (1929)).**

---

[5] **In the past, pursuant to the so-called "cold bed" rule, HCFA sometimes imposed downward adjustments in the number of waiver enrollees a State proposed to serve to reflect the State's actual capacity to provide institutional services to waiver recipients. *See Florida Department of Health and Rehabilitative Services,* DAB Decision No. 1100 (1989). But, in 1994, HCFA eliminated the requirement that there be available "cold beds" to house all waiver recipients (*see* 59 Fed. Reg. 37702 (1994)), thereby removing the rationale for such adjustments.**

This omission is especially significant because in the interim final rules that HCFA adopted in 1985 (see 50 Fed. Reg. 10013), the agency included in section 441.310 a provision specifying that FFP was "not available in expenditures for . . . Home and community-based services that exceed the agency's approved estimated total expenditures for these services, expressed as the product of (C X D) in the supporting documentation required under § 441.303(f) for each year of the waiver period." Adoption of this regulation represented an acknowledgment by HCFA that a rule making FFP unavailable because an approved waiver estimate is exceeded is one that is not enforceable unless it is adopted through notice-and-comment rulemaking.[6] The fact that HCFA amended section 441.310 to delete this provision, and did not replace it with a provision that would make FFP unavailable in expenditures for waiver enrollees in excess of the approved estimate, means that the agency has no authority to withhold FFP on the basis cited in the draft audit report.

Recommendation 15. Remove all provisions from existing laws, regulations, policies and procedures limiting access to services provided by an intermediate care facility for the mentally retarded (ICF/MR) for reasons other than medical necessity or inappropriate utilization. All personnel involved with DDD clients needs to receive instructions clarifying DDD clients who are eligible for Medicaid and qualify for ICF/MR services are entitled under the Medicaid State Plan to receive ICF/MR services without limitations. The State also needs to take the steps necessary to secure sufficient ICF/MR capacity to meet the needs of those individuals requesting ICF/MR services**.**

DSHS RESPONSE: It is our understanding that the federal government shares the state of Washington's interest in building a solid, reliable, credible community support system to deliver services so that people may live in the least restrictive environment closest to their homes and families. The current language in Recommendation # 15 will trigger a hostile and divisive debate in our state that will divert attention from the basic question of resource needs to the question of the place where needs are met.

We don't believe the federal government would intentionally set off that debilitating debate again in our state and we respectfully request that Recommendation # 15 be at best eliminated and at least rewritten.

If CMS is not able to eliminate this recommendation we would request that it be rewritten to say that:

"Federally-funded waiver services are a direct result of the willingness of an eligible recipient to receive community-based services as an alternative to the State Plan Service of Intermediate Care Facilities for the Mentally Retarded (ICF/MR). Washington must not enforce any state laws that limit access to ICF/MR services for eligible clients because federal law takes precedence over state law."

---

6 **Similarly, CMS policy about increases in enrollment under a section 1915(d) waiver is stated in the regulations governing section 1915(d) waivers. *See* 42 C.F.R. § 441.355(a)(4). The absence of any regulatory policy as to section 1915(c) waivers, such as the Washington CAP waiver, means that there is no such mandatory amendments-must-be-made-before-the-close-of-the-waiver-year policy as to 1915(c) waivers.**

Thank you for the opportunity to respond to the report. If you have any questions, or if you desire to discuss these matters further, please do not hesitate to contact me. For specific information about developmental disabilities services and management of the CAP Waiver program, you may also contact Linda Rolfe, Director of the Division of Developmental Disabilities. Her number is (360) 902-8484.

Sincerely,

DENNIS BRADDOCK
Secretary

Enclosure

cc: Timothy Brown
Linda Rolfe